STATE OF TEXAS

TEXAS DEPARTMENT OF HEALTH — BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
a. COUNTY: Dallas
b. CITY OR TOWN (If outside city limits, give precinct no.): Dallas
c. LENGTH OF STAY in 1 b.: 1 day
d. NAME OF (If not in hospital, give street address) HOSPITAL OR INSTITUTION: Parkland Hosp
e. IS PLACE OF DEATH INSIDE CITY LIMITS? YES [X] NO [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside city limits, give precinct no.)
d. STREET ADDRESS (If rural, give location)
e. IS RESIDENCE INSIDE CITY LIMITS? YES [ ] NO [ ]
f. IS RESIDENCE ON A FARM? YES [ ] NO [ ]

3. NAME OF DECEASED (Type or print): (a) First: John (b) Middle: F (c) Last: Kennedy

4. DATE OF DEATH: 22 Nov 19 63

5. SEX
6. COLOR OR RACE
7. Married [ ] Never Married [ ] Widowed [ ] Divorced [ ]
8. DATE OF BIRTH
9. AGE (In years last birthday) | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Minutes
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot wound of Brain — 1 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [X]
20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of Item 18.]
20c. TIME OF INJURY: Hour, a.m. p.m., Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office building, etc.)
20f. CITY, TOWN, OR LOCATION — COUNTY — STATE

21. I hereby certify that I attended the deceased from 22 Nov 19 63 to 22 Nov 19 63 and last saw the deceased alive on 22 Nov 19 63. Death occurred at 1300 m. on the date stated above, and to the best of my knowledge, from the causes stated.
(Degree or title)
22a. SIGNATURE: Malcolm O. Perry M.D.
22b. ADDRESS: 5323 Harry Hines
22c. DATE SIGNED: 22 Nov 63

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE

25a. REGISTRAR'S FILE NO.
25b. DATE REC'D BY LOCAL REGISTRAR
25c. REGISTRAR'S SIGNATURE

VS-112. REV. 1/58

orig to Supt. Hillery 11-27-63 RIB

IF DECEASED SERVED IN U.S. ARMED FORCES, FILL OUT THE FOLLOWING:

Is the deceased reported to have been in such service?
Name of organization in which service was rendered?
Serial number of discharge papers or adjusted service certificate?
** me of next of kin or of next friend?
Post Office Address?

IF DECEASED WAS MARRIED, FILL OUT THE FOLLOWING:

Name of husband or wife	Age in years

IF DECEASED IS AN UNIDENTIFIED PERSON, FILL OUT THE FOLLOWING:

Color of Hair?	Color of Eyes?	Height? Ft. In.	Weight?
Deformities?		Tattoo Marks?	
Other marks of identification?			